

Managing Personal and Professional Boundaries

How to Make the Physician's Own Issues, a Resource in Patient Care

- b. Encourage the patient to attend several sessions and "give it a fair try."
 - c. Tell the therapist the patient is reporting difficulty.
 - d. When treatment is stuck or ineffective, ask the therapist for his or her assessment. Consider consultation, termination, or referral to another mental health specialist.
7. Don't continue using a therapist who generally does not provide adequate feedback or effective treatment.

Empathy and sensitivity are resources in family-oriented primary care that are largely developed in the providers' own personal and family life. A physician's appreciation of the richness of emotional life, the complexity of human problems, and the humility inherent in human suffering forms the foundation for such empathy and fuels a successful doctor-patient relationship. A physician may be drawn to primary care in the first place because his or her upbringing has resulted in a highly developed sense of responsibility and altruism. Many primary care physicians played a caretaking role that was highly valued in their original families, and has led to a commitment to serving others and a sensitivity to illness and loss.

All this early family training is useful to the physician interested in the art of medicine. These caretaking dynamics contribute to making individuals into excellent, caring physicians. These same dynamics make it very important for providers to establish clear boundaries between work and family life to offset a tendency to get overinvolved with patients, patients' families, and work issues in general. Personal anxiety and/or a desire to maintain power or control over people can result in such overinvolvement (1). A clear sense of boundaries prevents this problem and supports the healthy dynamics that lead an individual to choose a career in primary care medicine. In this chapter, we will discuss several different aspects of managing personal and professional boundaries, including recognizing when one's own family of origin or one's own current family issues are impacting a patient encounter in a positive way and when to refer a patient to a colleague because of the potential negative effects of personal issues. We will also discuss the importance of role clarity in shifting from being a physician to a

use or family member, and vice versa, and provide some warning signs for problems in this area.

Physicians' Family of Origin Issues

Physicians' past and current personal issues can be either a major source or a profound hindrance in the doctor-patient relationship. Issues of caretaking and authority as well as tolerance for affect are all rooted in our families of origin. Many physicians are able to use their experiences to enhance their empathy and their credibility with patients. However, current problems or unresolved struggles from the past can cloud or distort our perceptions of patients and their families, creating personal issues as a resource depends on being able to recognize these issues when they occur in our work. When the physician recognizes that a patient or family is stimulating an important personal issue, the physician then has the opportunity to decide whether to treat, collaborate with a colleague, or refer.

Dr. Bayer came from a family of high achievers and heavy drinkers. When her parents divorced during her adolescence, she began attending Al-Anon while her mother attended Al-Anon. After his second marriage, her father finally entered alcohol treatment and began attending AA regularly. Alcoholism had caused her much pain in the past and became an area of interest to her as a physician. She read articles and sought supervision during residency for patient problems that involved alcoholism. Drawing on her experience with her own family, supervision helped her recognize that alcoholic patients and their families were the only people who could decide to change the problem. Dr. Bayer saw her role as assessing the problem and providing advice and support. By using her personal experience and professional training to great advantage, she became known for her skill in evaluating alcoholic families and eventually getting them into treatment. She felt great pride and satisfaction in helping these patients and became a referral source for colleagues who recognized they did not have the same skills.

Dr. Lane, by contrast, always had difficulty with her alcoholic patients. Her father was also a drinker. She suspected that his drinking contributed to the loud arguments and occasional physical fighting that still characterized her parents' marriage. Her father denied he was a "problem drinker" because he said he drank half as much as his own father who "did have a problem." Dr. Lane drank very little herself as did her husband, but her husband smoked marijuana on a daily basis because "it helps me relax." Dr. Lane found herself very interested in getting her alcoholic patients into treatment but felt she was never successful. She told her colleagues: "Alcoholics never change. There's no point in wasting your breath trying to convince them."

In this first example, Dr. Bayer was able to recognize and understand alcoholism clearly. She knew what she could contribute as a physician and what the patient and family would have to go through themselves.

Dr. Lane also had respect for the difficulty of the process. All these factors helped to make her comfortable working with alcoholic patients whether they were actively drinking or working to stay sober. Dr. Lane, on the other hand, was not clear how substance abuse had affected her own life. This same confusion occurred when trying to evaluate patients and whether or not they had a problem with drinking. Eventually, she became pessimistic about the potential for change, just as her own personal experience remained unchanged. For personal issues to be a resource, it is vital that the physician be able to recognize when an issue can be used to enhance professional skills (as with Dr. Bayer) and when it is unresolved (as with Dr. Lane). We all have issues in the latter category, and when patient problems overlap with them it is important to either refer, collaborate, or seek consultation. We do not do ourselves or our patients a service by treating them in isolation when our own unresolved personal experiences are a factor in their care.

A physician may be able to understand a particular problem in depth because of being personally familiar with it; on the other hand, the physician may not perceive a patient accurately because that patient reminds him or her of the physician's own family member. Recognizing when a patient or family triggers a personal issue for the provider is not always easy and requires sensitivity and experience. Each individual provider will have a set of idiosyncratic signals that alert him or her to a personally relevant dynamic occurring during an interview. The following are generic signals that a patient or family may be activating a personal issue for the physician:

1. Becoming overinvolved with a particular patient or family.
 - routinely having longer than usual sessions with this patient
 - allowing this patient or family easier access than is typical for you—e.g., allowing them to call you at home or interrupt you with another patient
 - your own family members complaining about this patient's behavior because it is pervading your own family life
2. Being underinvolved with a particular patient or family.
 - expanding the time between patient sessions because you would rather not see a patient
 - not returning a patient or family member's phone call
 - routinely asking your secretary or nurse practitioner to "take care of the problem"
3. Undue pessimism that people can change a particular problem behavior.
4. A strong feeling that a patient must change a particular problem behavior.
5. Prescribing the same treatment or "educating" a patient over and over again in spite of the fact that it is not working.

6. **Feeling reluctant to see a particular patient when you see his or her name on the schedule sheet.**
7. **Confusion about why your treatment is not working with this articular patient when it typically works with others.**
8. **Over-medicalizing or intellectualizing when discussing a patient's illness or problem.**
9. **Boredom, anger, or sadness with a patient or family out of proportion to the patient's problem.**

In the next examples, the first physician, Dr. Holmes, is able to recognize and utilize the signals that he is overreacting to the family while a second physician, Dr. Smith, does not attend to these signals and sees her patient.

Dr. Holmes felt particularly badly about having to tell a long-time patient that he had terminal cancer. Just after finishing with this patient and his family, he noticed that Mrs. Gerber was next on his schedule. His stomach twitched, and he wondered if he was getting a headache. Mrs. Gerber was a demanding patient who made Dr. Holmes feel as if he never gave her enough. "I wonder what her complaint will be today," he thought. Sure enough, Mrs. Gerber looked irritated when he walked in the room. "What took you so long?" she asked. Dr. Holmes found himself wanting to say, "I had someone with a real illness to deal with." Instead, he said, "I'm sorry. We get backed up here from time to time. What can I do for you today?" After the session, while reflecting on his day, Dr. Holmes wondered why Mrs. Gerber got to him so much. While discussing it with his partner, he realized Mrs. Gerber made him feel the way he used to with his mother: no matter what he did, he couldn't please her. And perhaps for the same reason: as an adult, Dr. Holmes had come to realize that his mother had a longstanding underlying depression. Now he began to wonder about Mrs. Gerber's psychosocial situation, how much support she had, and whether she might have a clinical depression. He decided to do a more in-depth evaluation of her mental status and her affect and try to involve her family and friends in the evaluation to test her support network. After the conversation with his colleague, Dr. Holmes realized he was actually looking forward to the next session with Mrs. Gerber because he was curious to find out what was driving her unhappiness.

Dr. Smith had the reputation of being a caring, effective physician. She was responsible and responsive, though she did not have many friends. Dr. Smith did a lot of counseling in her practice. Though she did not enjoy it much, she felt it was part of her job as a doctor and she also was convinced that few patients would accept a referral to a mental health specialist. Today she had to see a patient in the ICU who had come very close to overdosing on the antidepressant Dr. Smith had prescribed for her. The overdose surprised Dr. Smith. She had been doing individual counseling with this young housewife for four months and had described the patient in her chart as "bright and sensible." At the hospital, the patient told her that she had had another argument with her husband, become frustrated, and "wanted a way out." Dr. Smith decided this woman was more impulsive than she had realized, and

bluntly told her in the hospital that she needed to see a psychiatrist. The patient was offended by Dr. Smith's abruptness. She decided Dr. Smith did not truly understand how miserable she felt, and she switched to another primary care physician.

Without realizing it, Dr. Smith was repeating a pattern established in her own family of origin. When she was 10, her own mother had committed suicide after several counseling sessions with her internist. The family had handled this death by trying to "move on." Dr. Smith's father remarried quickly and her mother was rarely discussed in family gatherings. Dr. Smith worked hard to take care of her brother and sister. She felt she had adapted to this tragedy as well as possible, but in fact she had little support and had spoken to virtually no one about the loneliness and confusion that plagued her memories of her mother. Instead, Dr. Smith poured herself into her work and was vulnerable to taking on too much counseling, too much responsibility with patients, and not recognizing patients at high risk for major depression or suicide.

Most providers find that utilizing personal issues as a resource requires trusted colleagues with whom to discuss challenging cases. Balint groups (2), and their latter-day offshoots that utilize a family perspective (3,4) offer a vehicle to physicians to explore their own personal issues vis-a-vis clinical cases. Some of these groups use both the patients and the physician's genogram as tools to discover any similarities that may be meaningful in the doctor-patient relationship. Several family-oriented primary care physicians have recommended that physicians use a Bowenian approach (5) to work on their own family of origin issues as a method of becoming more effective professionally (6-8).

The Physician's Current Family Issues

Issues in the physician's current family life can also be either a resource or a problem for patient care.

Dr. Orion's parents visited her for the first time in her new home soon after the arrival of her first child. Because Dr. Orion practiced obstetrics, she was prepared for the joy, the physical pain, and the fatigue that accompanied having a child. She was not, however, prepared for what happened when her parents visited. Her parents were clearly delighted at the arrival of their first grandchild, however her mother could not stop telling her what to do with the baby. No matter what Dr. Orion did with her baby, her mother had a better way to do it. After breathing a sigh of relief at her parents' departure, Dr. Orion returned to patient care and found herself interested in how new parents negotiated the change in their relationship with their own parents. She collaborated with a family therapist on a study of the relationship between new parents, grandparents, and infant morbidity. She also developed clinical guidelines for patients to obtain support and guidance from their own

paren ' before or soon after the delivery of their first child. Dr. Orion tested in jelines by applying them to her relationship with her own parents and recognizing them in their new role as grandparents.

While Dr. Orion was able to use her own experience to be helpful to her patients, Dr. Waters found himself discontent and overwhelmed with patients whose problems resembled his own.

Dr. Waters felt drained and tired at the end of each workday. He realized that ever since he and his wife had been discussing separation, his tolerance for hearing about patients' marital problems was very low. One female patient that he had previously enjoyed working with now seemed demanding and needy. She complained her husband did not listen to her and cared more about work than he did about her, complaints amazingly close to those of Dr. Waters' own wife. Dr. Waters continued to see this patient, though he spaced her appointments out as much as she would tolerate.

All personal experiences have the potential of enriching our professional lives. However, private stresses and struggles that are occurring in the moment, and so by definition are unresolved, run the biggest risk of leading to difficulties in the doctor-patient relationship. A trusted colleague or a Balint-like group can be very helpful in sorting out these issues. It is important to us and to our patients that we give ourselves permission to collaborate or refer when patients' problems hit "too close to home."

Studies have shown physicians to have particular difficulty with depression and substance abuse (9-11). Additionally, they are susceptible to having problems in their own marriages related to workaholicism, or what Gerber calls being "married to their careers" (12). Several strategies are important to help the physician deal with current family problems:

- develop a willingness to seek help oneself when it is needed,
- develop a lifestyle that provides a balance between work and personal life,
- establish appropriate boundaries between work and home life, so that some time is protected for personal and family needs to be met without the intrusion of patients, and
- develop clarity about when one is in a professional role, with the challenges and rewards of being a professional, and when one is in a family role, with the challenges and rewards of being a family member.

Role Clarity:

To Be or Not to Be Your Own Family's Physician

A natural facet of being a family member is caring about the health and well-being of loved ones. This function is somewhat complicated when one or more family members is a professional health provider. When and how much to use one's professional expertise with family members can

be a challenging issue. Many families consciously or unconsciously train their children to be caretakers of some kind. It is quite natural then, when one does become a health care provider, to feel some conflict about how much to take care of one's own family's medical concerns. In any given situation if a provider decides to be his or her own family's physician, that role allows the physician to express concern and caring through using medical skills and it allows the patient/family member to feel cared about . . . until there is a bad outcome. Then, the physician and the family will question the medical decision-making process and an undue amount of guilt and responsibility may become part of the already complex relationships between the physician and his or her family. If the physician refuses to use his or her special expertise with family members, the patient/family member may feel uncared for or abandoned and the physician may feel badly about not being "helpful" in an area where he or she does have some special skill.

Being clear about whether one is functioning as a professional or as a family member is essential to resolving this dilemma. It is difficult to develop the neutrality and distance necessary to make clear diagnoses and implement potentially difficult treatment plans if one is a family member of the patient, and it is difficult to allow oneself to advocate for and care deeply about a family member if one is responsible for his or her medical care. One solution is to develop a relationship with a respected primary care physician who is outside the family. Turning to this person frees the physician to enjoy the family member role, yet have confidence that the patient is receiving quality medical care.

Without a clear distinction between the roles of health care provider and family member, it is easy for the physician to become either overinvolved or underinvolved in the family member's medical care. Some physicians may characteristically overfunction in their professional role, so that they tend to become overinvolved in the medical care of family members. In this situation, it is easy to avoid important emotional issues by intellectualizing or medicalizing about a loved one's condition. Others may underfunction and not provide concern or support unless a family member has a "truly serious" illness. Either problem is dangerous because it results in the physician underfunctioning as a family member. Every physician needs to examine his or her style, philosophy, and practice setting and consciously set boundaries with regard to dealing with family medical issues. The specifics of these boundaries will vary from individual to individual. Some practice settings with few physicians, such as those in rural settings, make setting boundaries more challenging though all the more important. The following are general warning signs of overinvolvement with your own family's medical concerns, signs of slipping into the difficult role of being your own family's physician:

1. When you counsel or advise family members about some health issue more than one time.

- when you give frequent advice about some family member's significant health concern and find that the relative is not going to his or her physician about the problem.
 - when you repeatedly try to get a family member to adopt a more healthy lifestyle and change behaviors such as diet, smoking, and exercise.
2. When you, and only you, take care of family health matters.
 - when you are the only person who speaks to your ill family member's physician.
 - when you are the person who coordinates the care of the family member among the specialists.
 3. When you, instead of an independent physician, evaluates a family member's illness.
 - when you do a physical exam on a family member.
 - when you order tests on a family member.
 - when you write a referral letter to have a family member evaluated further.
 4. When you treat a family member for an illness for which most people see a physician.
 - when you write a prescription for medication for a family member.
 - when you assist in the surgery of a family member (deliver a baby, run a code, etc.).

The following is an example of a physician who became overinvolved in her grandmother's medical care.

Dr. Rudder was raised by her grandmother after her mother died at a very early age. Her grandmother was very proud of "her granddaughter, the doctor." Soon after Dr. Rudder set up a practice as a primary care physician in a distant urban setting, her grandmother had a stroke in her rural hometown.

Dr. Rudder rushed to the hometown hospital to see her grandmother and found her in the care of an older physician who she was unsure was "up to date" medically. Dr. Rudder was quite upset about her grandmother's illness and the thought that she might die, but she had difficulty focusing on these feelings. Instead, she found herself making demands of the floor nurses as if she were the attending, and strongly suggesting alternative treatment plans to her grandmother's physician. Dr. Rudder knew there was much she wanted to say to her grandmother: how she appreciated all her sacrifice in raising her, how she admired her stubborn strong will, how she loved her. But, instead, she found herself obsessed with her grandmother's medical care. Frustrated that perhaps it was not the best, Dr. Rudder suggested to her grandmother that she change physicians to one of her colleagues in residency who had opened a practice not too far away. To Dr. Rudder's disappointment and irrita-

tion, her grandmother made it clear that she had a long-term relationship with her physician, that she had complete confidence in him, and that she had no desire to change physicians at this point in time.

During the hospitalization, Dr. Rudder functioned as the primary family link to her grandmother's physician. Other family members pumped her for information and relied on her to relay any questions to her grandmother's doctor. Dr. Rudder felt trapped, unsatisfied with her role, worried about her grandmother and exhausted. Her grandmother died one week after being hospitalized.

Unfortunately, Dr. Rudder confused her role as physician with her role as family member. Her medical knowledge interfered with her being able to successfully deal with the important emotional issues that confronted her with the illness and impending death of her grandmother. Her lack of confidence in her grandmother's doctor made it that much more difficult for her to leave her medical care in his hands. As a result, she was unable to maintain a clear boundary around her most important role in this situation, that of granddaughter.

While some physicians tend to become overinvolved in family member's health issues, others respond to the same stress by becoming underinvolved. The following are warning signs of underinvolvement with your own family's medical concerns, signals that the rest of the family may read as a lack of caring:

1. When you do not want to hear anything about a family member's symptoms.
2. When you never comment on or discuss the medical issues of a family member.
3. When you do not provide support or sympathy for the everyday symptoms or aches and pains of family members.
4. When you avoid contact or conversation with the ill family member.

The following is an example of a physician who was underinvolved in his children's lives.

Dr. Christopher had a style his patients likened to Marcus Welby. He was always available to them, morning, noon, and night. They worshipped him, and even stopped his children on the street to tell them what a wonderful man he was. His family was organized around supporting Dr. Christopher's dedication to his job. His wife ran the household and raised the children. His children were used to the fact that he rarely came to their baseball games or school plays. They also knew that unless they had some dire illness or injury, their father was unlikely to show much concern. "He sees so much serious illness, he knows this is not a problem," their mother would tell them. Unfortunately, his children grew up not realizing their father's loneliness or the depth of feeling he had for them.

PROTOCOL

How to Manage Personal and Professional Boundaries As a Health Care Provider

patient care; signals that a patient or family may be activating a personal issue for the physician.

- Becoming overinvolved with a particular patient or family.
- Being underinvolved with a particular patient or family.
- Undue pessimism that people can change a particular problem behavior.
- A strong feeling that a patient must change a particular problem behavior.
- Prescribing the same treatment or "educating" a patient over and over again in spite of the fact that it is not working.
- Feeling reluctant to see a particular patient when you see his or her name on the schedule sheet.
- Confusion about why your treatment is not working with this particular patient when it typically works with others.
- Over-medicalizing or intellectualizing when discussing a patient's illness or problem.
- Boredom, anger, or sadness with a patient or family out of proportion to the patient's problem.

Family life:

1. Warning signs of overinvolvement with your own family's medical concerns.

1. When you counsel or advise family members about some health issue more than one time.
 - a. when you give frequent advice about some family member's significant health concern and find that the relative is not going to his or her physician about the problem.
 - b. when you repeatedly try to get a family member to adopt a more healthy lifestyle and change behaviors such as diet, smoking, and exercise.
2. When you, and only you, take care of family health matters.
 - a. when you are the only person who speaks to your family member's physician.
 - b. when you are the person who coordinates the care of the family member among the specialists.
3. When you, instead of an independent physician, evaluates a family member's illness.
 - a. when you do a physical exam on a family member.

- b. when you order tests on a family member.
- c. when you write a referral letter to have a family member evaluated further.
4. When you treat a family member for an illness for which most people see a physician.
 - a. when you write a prescription for medication for a family member.
 - b. when you assist in the surgery of a family member (deliver a baby, run a code, etc.).

- B. Warning signs of underinvolvement with your own family's medical concerns.

1. When you do not want to hear anything about a family member's symptoms.
2. When you never comment on or discuss the medical issues of a family member.
3. When you do not provide support or sympathy for the everyday symptoms or aches and pains of family members.
4. When you avoid contact or conversation with the ill family member.

Under- or overinvolvement in family member's medical concerns can lead to personal pain and interpersonal difficulty. Conscious decisions about boundaries between work and family life make a balanced lifestyle more likely.

Conclusion

Family-oriented primary care begins at home. Physicians' unresolved past or current personal problems play a role in their diagnosis and management of patients, either wittingly or unwittingly. Stephens, in an essay that called for physicians to examine their personal and societal stands regarding the family, said: "Let us boldly become more 'pro family', perhaps attending first to ourselves in our own family roles" (13). The secret to successful caretaking may be the recognition that we cannot change another's behavior, rather we can only change our own. While we are responsible for professional medical care (the diagnosis and treatment), the patient remains in charge of his or her own health (reporting symptoms, collaborating in the history and exam, and final decision making regarding treatment). Patient care can benefit from physicians establishing these boundaries and focusing on changing our own behavior when needed. The dictum, "Physician, heal thyself," may be one of the most powerful therapeutic agents for any physician's patients.

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**Leaving It at the
Office:
Psychotherapist
Self-Care**

John C. Norcross, Ph.D.

Description/Objective

Conducting brief Tx places additional and special burdens on the person of the therapist. This lecture puts the Socratic dicta of "know thyself" and "heal thyself" into practice. We shall focus on self-care strategies that are clinician recommended, research based, and practitioner tested.

What We Will NOT Do

- Light candles
- Inflate balloons
- Burn paper regrets
- Meditate together
- Practice specific skills

What We WILL Do

- Traverse the accumulating research on self-care
- Emphasize self-care principles or strategies (not techniques)
- Think with the mind of a scientist, feel with the heart of a humanist
- Embrace multiple strategies associated with diverse theoretical orientations

Theoretical Orientation and Patient Care

In treating patients, change processes vary reliably with the therapist's theory

E.g., CBT therapists use counterconditioning, contingency management, and stimulus control significantly more

E.g., Psychodynamic therapists rely more on the therapy relationship and catharsis

Theoretical Orientation and Self-Care

No differences in self-care principles due to therapist's theory

Not even a few statistically significant differences expected by chance alone.

Results strongly argue for considerable similarity among psychotherapists in their own self-care

Why No Differences?

1. In psychotherapist role, people rely heavily on theories for facilitating change in others. But in self-change role, people are not as influenced by theory.
2. A cynical perspective on the duplicity between public careers and personal lives. Therapists may not avail themselves of what they offer their patients.
3. Therapists become more pragmatic, eclectic, and secular in their own self-care.

Self-Care Checklist

REFOCUSING ON THE REWARDS

- ✓ Focus on the rewards associated with clinical work that bring life and vitality. For example, recall the life-transforming psychotherapies in which you were privileged to participate.
- ✓ Look for ways to create a greater sense of freedom and independence in your work.
- ✓ Variety and intellectual stimulation are indispensable. What can you do to increase their impact on your schedule and professional duties?
- ✓ Is your emotional growth being properly and regularly sharpened?
- ✓ Satisfaction from helping others is crucial, so be sure to include at least some clinical activities that demonstrate you are actually helping someone!
- ✓ Enjoy maintaining relationships with clients that span years, even decades, that include intermittent courses of treatment.
- ✓ Your work will ideally capitalize on both your natural and acquired abilities. Do what you do well.
- ✓ A sense of humor and the absurd is one of your most potent stress relievers. Practice!
- ✓ Be careful when applying your expertise to your family of origin... fools rush in where angels fear to tread.
- ✓ How has clinical practice improved the quality of your friendships?
- ✓ Yes, you are an expert on human behavior -- but you're still nutty at times!
- ✓ Remember: you are actually self-employed, regardless of who you work for. Maintaining this perspective brings great freedom of choice.
- ✓ Clinical practice may not make you rich, but if it is your calling, it is a wonderful way to make a living.
- ✓ There are typically many more benefits than hazards associated with the practice of psychotherapy. If you've forgotten this, find methods to help you remember.

RECOGNIZING THE HAZARDS OF AN "IMPOSSIBLE PROFESSION"

- ✓ All accounts indicate that clinical practice exacts a negative toll on the practitioner, particularly in the form of problematic anxiety, moderate depression, and emotional underinvolvement with family members. Have you identified the impact of clinical practice on you and your loved ones?
- ✓ Reading about and reflecting on the stresses of psychotherapy commonly leads to the realization that similar strains are experienced by virtually all mental health professionals. Can you affirm the universality of these stresses?
- ✓ Consider the amount of physical isolation that you experience each day. What steps can you take to create more opportunities for contact with other clinicians?
- ✓ Try to include phone calls, lunches, and breaks in your workday several times each week to provide contact with family and friends.
- ✓ Consider taking steps to create variety in your day, such as intermingling psychotherapy sessions with supervision, consultations, study breaks, a trip to the gym, and so on.
- ✓ Invite family and friends to point out when you become too interpretive and "objective" when it would be healthier to be spontaneous and genuine.
- ✓ The possibility of patient violence is disturbing but important to consider. How can you act now to enhance your personal safety at the office?
- ✓ Take Coach John Wooden's advice and refuse to believe either your most idealizing or your most demeaning client -- you are neither God nor the devil.
- ✓ Do you frequently hear stories of abuse and cruelty in your work with clients? Limit your exposure to traumatic images outside the therapy room by choosing movies, literature and other entertainment carefully.

SETTING BOUNDARIES

- ✓ Setting boundaries emerges in our research as the most frequent self-care strategy of mental health professionals. Be clear with your clients about professional expectations and limitations.
- ✓ Clearly delineate your policies regarding extra sessions, late appointments, telephone contacts, payment for services, and the like.
- ✓ Your work expresses a combination of personal style, theoretical orientation, and individual preferences. Caring professionals customize their work to individual patients, but there is a limit to bending.
- ✓ Clarify your expectations of your clients early in your work. What are the ground rules for treatment?
- ✓ Saying good-bye to clients well requires clear statements concerning how, when, and why treatment may resume in the future.
- ✓ Understand what your client needs most, and don't allow that goal to be compromised by conflicting roles and agendas.
- ✓ Your clients are not there to meet your needs;- treatment relationships are not reciprocal.
- ✓ Define your relationships with colleagues with care. Transference influences these relationships, too.
- ✓ Establishing an identity apart from your role as a clinician will enrich your private life with variety and meaning. Don't get stale!
- ✓ Let your hair down with family and friends. They want you to be genuine, spontaneous, and unprofessional.

RESTRUCTURING COGNITIONS

- ✓ Self-monitor your internal dialogue, particularly in regard to countertransference feelings.
- ✓ Attend to what Ellis calls "stinking thinking" through introspection, reflection, using triple column logs, or sharing concerns with others.
- ✓ Think through your reactions to transference feelings directed to you. To whom are they aimed and to whom do they belong?
- ✓ Beware of absolutistic thinking: masturbation and the tyranny of the shoulds. They can affect you as much as your patients.
- ✓ Dispute the common fallacy that "good psychotherapy is equivalent to having all patients who like us." It is not!
- ✓ Yes, you are an expert on human behavior -- but you're still nutty at times!
- ✓ Recall that the other side of caring consists of confrontation. Caring about others includes being tough, at times.
- ✓ Reassure yourself that the conditions in psychotherapy, as well as in life, are not always easy. This is unfortunate but not catastrophic.
- ✓ To fail is human. To consider yourself a failure is not divine.
- ✓ Remind yourself that you cannot cure every patient.
- ✓ Balance the amount of time you devote to thinking about your successful cases and your frustrating cases. Dwell on your successes as well as your failures.
- ✓ Assertively lessen unrealistic demands made on you: don't take on more work than you need to or wrongly believe you're expected to do more.
- ✓ Catch yourself when you assume personal causality. Self-deprecation is self-defeating!
- ✓ Consider alternate explanations that may cause events. Psychotherapy is not the only causal event in clients' lives.
- ✓ Calculate real probabilities. The worst does not always happen -- to you or to your patients.
- ✓ Evaluate events on a continuum to avoid dichotomous thinking; psychotherapy outcomes are rarely a either extreme of a continuum.

valued mentor, trusted colleague, or former therapist.

CULTIVATING SPIRITUALITY AND MISSION

- ✓ We emphasize the personal experience of spirituality or what Maslow called *mission*. Can you identify and resonate to an abiding mission or spirituality?
- ✓ Embrace your sense of calling to be a clinician. What are the spiritual antecedents to your career choice?
- ✓ Your work grows out of a legacy of socially sanctioned healers that extends back for many centuries. Try to feel connected to the heritage and to the privilege of practicing psychotherapy. It is not the successful practice of psychotherapy that provides meaning; it is a life of deep personal meaning that makes effective psychotherapy possible.
- ✓ Connect to the spiritual sources of your hope and optimism regarding human behavior. If you have lost your enduring sense of care and concern for others, get help.
- ✓ A sense of personal mission can fruitfully incorporate larger societal concerns, such as enhancing women's rights, promoting social justice, teaching conflict resolution, eradicating poverty, and abolishing sexual abuse. What are the sympathies that renew you?
- ✓ Optimism and belief in the potential for personality change are prerequisites for good clinical practice. Assess yourself and then ask a friend to assess you.
- ✓ How does your belief in a mission, God, or a transcendent force influence your work? How does this serve as a resource for you? Are you squarely confronting your own yearnings for a sense of transcendence and meaning?
- ✓ Try to invoke and augment your client's spirituality world view to enrich their experience of psychotherapy.
- ✓ Who serves as a spiritual mentor for you? Is this adequate?
- ✓ Since the practice of psychotherapy is not to provide ultimate meaning for your life, what does? What should?
- ✓ How have you progressed in answering the ultimate questions concern life and the meaning of our existence? Are you squarely confronting your own doubts and yearnings for a sense of transcendence and meaning?
- ✓ Assess the integration of spirituality and personal growth in your own life. How are you doing? What are you doing to promote such a synthesis?

FOSTERING CREATIVITY AND GROWTH

- ✓ Opportunities for dedicated reflection and discernment are a professional obligation, not a luxury. How often do you engage in spiritual exercises, journaling, meditation, or other forms of renewal?
- ✓ Are you finding ways of nurturing your creativity? Are staleness and repetition starting to get you down?
- ✓ Diversify, diversify, diversify.
- ✓ Attending clinical conferences, reading literature, and continuing your education are the life springs of a committed professional. Do you feel you are just getting CE hours or truly refining and building your skills?
- ✓ "Everything comes together for a therapist in the creative process" (Kottler, 1991, p. 238). How are you coming together, nourishing yourself, and growing as a psychotherapist?

Adapted with permission from: Norcross, J. C., & Guy, J. D. (2003). *Leaving it at the office: Psychotherapist self-care*. New York: Guilford Publications.